		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026914

Facility Name: Concord Extended Care

Address: 9401 South Ridgeland (Number) Oak Lawn (City) 60453 (Zip Code)

County: Cook

Telephone Number: (708) 449-9090 **Fax #** (708) 449-7070

IDPA ID Number: 362833027001

Date of Initial License for Current Owners: 00/00/67

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	134	Skilled (SNF)	134	49,044	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	134	TOTALS	134	49,044	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	29,124	1,731	5,096	35,951	8
9	SNF/PED					9
10	ICF		6,064		6,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,124	7,795	5,096	42,015	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.67%

D. How many bed-hold days during this year were paid by Public Aid?
31 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1962

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 3,341

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,352	33,426	13,064	246,842		246,842	(5,548)	241,294			1
2	Food Purchase		156,848		156,848	(21,338)	135,510	2,886	138,396			2
3	Housekeeping	168,620	53,008		221,628		221,628	(4,215)	217,413			3
4	Laundry	82,458	22,978	597	106,033		106,033	(38)	105,995			4
5	Heat and Other Utilities			92,847	92,847		92,847	1,050	93,897			5
6	Maintenance	42,938	98	105,355	148,391		148,391	(1,172)	147,219			6
7	Other (specify):*							3,539	3,539			7
8	**TOTAL General Services**	494,368	266,358	211,863	972,589	(21,338)	951,251	(3,497)	947,754			8
	B. Health Care and Programs											
9	Medical Director			5,960	5,960		5,960		5,960			9
10	Nursing and Medical Records	1,677,399	51,683	156,124	1,885,206		1,885,206	1,557	1,886,763			10
10a	Therapy	73,822		1,416	75,238		75,238	(692)	74,546			10a
11	Activities	76,456	4,298	2,238	82,992		82,992		82,992			11
12	Social Services	94,085		8,850	102,935		102,935	7,553	110,488			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,437	4,437			15
16	**TOTAL Health Care and Programs**	1,921,762	55,981	174,588	2,152,331		2,152,331	12,856	2,165,187			16
	C. General Administration											
17	Administrative	114,833		78,700	193,533		193,533	(12,372)	181,161			17
18	Directors Fees											18
19	Professional Services			243,453	243,453		243,453	(182,566)	60,887			19
20	Dues, Fees, Subscriptions & Promotions			59,683	59,683		59,683	(31,066)	28,617			20
21	Clerical & General Office Expenses	80,497	16,933	349,582	447,012		447,012	(196,128)	250,884			21
22	Employee Benefits & Payroll Taxes			381,830	381,830	21,338	403,168	(14,157)	389,011			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,467	1,467		1,467	2,858	4,325			24
25	Other Admin. Staff Transportation			6,833	6,833		6,833	(5,484)	1,349			25
26	Insurance-Prop.Liab.Malpractice			126,687	126,687		126,687	629	127,316			26
27	Other (specify):*							17,758	17,758			27
28	**TOTAL General Administration**	195,330	16,933	1,248,235	1,460,498	21,338	1,481,836	(420,528)	1,061,308			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,611,460	339,272	1,634,686	4,585,418		4,585,418	(411,169)	4,174,249			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Concord Extended Care #0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			68,444	68,444		68,444	115,841	184,285			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,209	3,209		3,209	244,234	247,443			32
33	Real Estate Taxes							156,026	156,026			33
34	Rent-Facility & Grounds			516,203	516,203		516,203	(512,600)	3,603			34
35	Rent-Equipment & Vehicles			1,274	1,274		1,274	1,266	2,540			35
36	Other (specify):*							20,432	20,432			36
37	**TOTAL Ownership**			589,130	589,130		589,130	25,199	614,329			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		238,671	266,759	505,430		505,430	(12,624)	492,806			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,566	73,566		73,566		73,566			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		238,671	340,325	578,996		578,996	(12,624)	566,372			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,611,460	577,943	2,564,141	5,753,544		5,753,544	(398,595)	5,354,949			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5)	02		4
5	Telephone, TV & Radio in Resident Rooms	(284)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	52,921	30		9
10	Interest and Other Investment Income	(20,198)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(287)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,000)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(224,000)	21		24
25	Fund Raising, Advertising and Promotional	(4,818)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,900)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,366)	20		28
29	Other-Attach Schedule	(124,533)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (339,470)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(59,125)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (59,125)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (398,595)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Concord Extended Care

ID# 0026914

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Other Income	$ (1,305)	21	1
2	Jury Duty	(17)	21	2
3	Patient Clothing	(72)	10	3
4	Psychiatric Consultant - Prior Year Expense	(300)	10	4
5	Collection Expense	(84)	21	5
6	IL Council COPE Payments	(1,711)	20	6
7	VA Pharmacy	(5,759)	10	7
8	VA Air Fluid Beds	(65)	10	8
9	Professional Fees - Bldg Co	(8,400)	19	9
10	Bank Charges - Bldg Co	(24)	21	10
11	Amortization - Bldg Co	(2,245)	36	11
12	Licenses and Fees - Bldg Co	(250)	20	12
13				13
14	Capitalized R&M	(6,043)	06	14
15	PPA - Sales Tax	(12)	02	15
16	PPA - Franchise Tax	(2,000)	21	16
17	PPA - Payroll Taxes	(765)	22	17
18	PPA - Uniforms	(35)	22	18
19	PPA - 401K Expense	(1,640)	22	19
20	Non-Allowable Salary	(22,068)	17	20
21	Non-Allowable Salary - Benefits	(3,894)	22	21
22	NonAllowable Expense	(67,844)	21	22
23				23
24				24
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100				**100**
101	Total	**(124,533)**		**101**

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					275		(2,347)	(3,476)				(5,548)	1
2	Food Purchase	(304)							3,190				2,886	2
3	Housekeeping				(4,215)								(4,215)	3
4	Laundry				(38)								(38)	4
5	Heat and Other Utilities					1,050							1,050	5
6	Maintenance	(6,043)			(14)	1,121		3,740	24				(1,172)	6
7	Other (specify):*						2,301	914	324				3,539	7
8	**TOTAL General Services**	(6,347)			(4,267)	2,446	2,301	2,307	62				(3,497)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(6,196)			(5,319)			13,072					1,557	10
10a	Therapy				(692)								(692)	10a
11	Activities													11
12	Social Services							7,553					7,553	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,420	3,017					4,437	15
16	**TOTAL Health Care and Programs**	(6,196)			(6,010)		1,420	23,642					12,856	16
	C. General Administration													
17	Administrative	(22,068)						9,538	158				(12,372)	17
18	Directors Fees													18
19	Professional Services	(8,400)	8,400			(182,582)			16				(182,566)	19
20	Fees, Subscriptions & Promotions	(21,145)	250			(10,180)			9				(31,066)	20
21	Clerical & General Office Expenses	(299,458)	24			10,242		92,778	286				(196,128)	21
22	Employee Benefits & Payroll Taxes	(6,334)		(500)	(521)		(6,802)						(14,157)	22
23	Inservice Training & Education													23
24	Travel and Seminar					2,787			71				2,858	24
25	Other Admin. Staff Transportation					(5,484)							(5,484)	25
26	Insurance-Prop.Liab.Malpractice					568			61				629	26
27	Other (specify):*						2,913	14,845					17,758	27
28	**TOTAL General Administration**	(357,405)	8,674	(500)	(521)	(184,649)	(3,889)	117,161	601				(420,528)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(369,948)	8,674	(500)	(10,798)	(182,203)	(168)	143,110	663				(411,169)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	52,921	50,347			10,412				2,161			115,841	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,198)	264,182						9	241			244,234	32
33	Real Estate Taxes		154,729			1,297							156,026	33
34	Rent-Facility & Grounds		(516,203)			3,274			329				(512,600)	34
35	Rent-Equipment & Vehicles					1,259			7				1,266	35
36	Other (specify):*	(2,245)	22,677										20,432	36
37	**TOTAL Ownership**	30,478	(24,268)			16,242			345	2,402			25,199	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(4,287)				(3,867)	(4,470)			(12,624)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(4,287)				(3,867)	(4,470)			(12,624)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(339,470)	(15,594)	(500)	(15,085)	(165,961)	(168)	143,110	(2,859)	(2,068)			(398,595)	45

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule		See Attached Schedule		See Attached Schedule		
				Concord Health Care Properties		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 516,203	Concord Health Care Properties, LLC	100.00%		$ (516,203)	1
2	V	32	Interest Income	639	Concord Health Care Properties, LLC	100.00%		(639)	2
3	V	19	Professional Fees		Concord Health Care Properties, LLC	100.00%	8,400	8,400	3
4	V	21	Bank Charges		Concord Health Care Properties, LLC	100.00%	24	24	4
5	V	30	Depreciation		Concord Health Care Properties, LLC	100.00%	50,347	50,347	5
6	V	36	Amortization		Concord Health Care Properties, LLC	100.00%	2,245	2,245	6
7	V	33	Real Estate Tax Expense		Concord Health Care Properties, LLC	100.00%	154,729	154,729	7
8	V	20	License & Fee		Concord Health Care Properties, LLC	100.00%	250	250	8
9	V	32	Interest Expense		Concord Health Care Properties, LLC	100.00%	264,821	264,821	9
10	V	36	MIP Expense		Concord Health Care Properties, LLC	100.00%	20,432	20,432	10
11	V								11
12	V								12
13	V								13
14	Total			$ 516,842			$ 501,248	$ * (15,594)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 92,031	$ 92,031	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	92,531	CCS EMPLOYEE BENEFIT GROUP	100.00%		(92,531)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 92,531			$ 92,031	$ * (500)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$	XCEL MEDICAL SUPPLY, LLC	100.00%	$	$	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	28,412	XCEL MEDICAL SUPPLY, LLC	100.00%	24,197	(4,215)	17
18	V	04	LAUNDRY	254	XCEL MEDICAL SUPPLY, LLC	100.00%	217	(38)	18
19	V	06	REPAIRS & MAINTENANCE	92	XCEL MEDICAL SUPPLY, LLC	100.00%	78	(14)	19
20	V	10	NURSING	35,849	XCEL MEDICAL SUPPLY, LLC	100.00%	30,531	(5,319)	20
21	V	10A	THERAPY	4,662	XCEL MEDICAL SUPPLY, LLC	100.00%	3,970	(692)	21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	3,512	XCEL MEDICAL SUPPLY, LLC	100.00%	2,991	(521)	24
25	V	39	ANCILLARY	28,897	XCEL MEDICAL SUPPLY, LLC	100.00%	24,609	(4,287)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 101,677			$ 86,592	$ * (15,085)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 275	$ 275	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,050	1,050	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,121	1,121	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	188,236	Care Centers, Inc.	100.00%	5,654	(182,582)	20
21	V	20	Dues and Subscriptions	12,136	Care Centers, Inc.	100.00%	1,956	(10,180)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	10,242	10,242	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,787	2,787	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	568	568	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	10,412	10,412	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,297	1,297	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	3,274	3,274	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,259	1,259	29
30	V	25	Bus Reimbursement	5,484	Care Centers, Inc.	100.00%		(5,484)	30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 205,856			$ 39,895	$ * (165,961)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 15,725	Care Centers, Inc.	100.00%	$ 15,725	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,301	2,301	16
17	V	10	Nursing Salary	5,731	Care Centers, Inc.	100.00%	5,731		17
18	V	10a	Rehab Salary	1,416	Care Centers, Inc.	100.00%	1,416		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	2,559	Care Centers, Inc.	100.00%	2,559		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,420	1,420	21
22	V	17	Administration Salary	3,117	Care Centers, Inc.	100.00%	3,117		22
23	V	21	Office Salary	16,798	Care Centers, Inc.	100.00%	16,798		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	2,913	2,913	24
25	V	22	Employee Benefits	6,802	Care Centers, Inc.	100.00%		(6,802)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,148			$ 51,980	$ * (168)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 4,854	Care Centers, Inc.	100.00%	$ 2,507	$ (2,347)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	3,740	3,740	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	914	914	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	13,072	13,072	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	7,553	7,553	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,017	3,017	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	9,538	9,538	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	92,778	92,778	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	14,845	14,845	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,854			$ 147,964	$ * 143,110	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 6,302	Care Centers, Inc. - Health Systems Division	100.00%	$ 614	$ (5,688)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	3,190	3,190	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	24	24	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	158	158	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	16	16	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	9	9	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	286	286	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	71	71	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	61	61	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	9	9	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	329	329	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	7	7	26
27	V	39	Ancillary Enteral Supplies	7,830	Care Centers, Inc. - Health Systems Division	100.00%	3,963	(3,867)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	2,212	2,212	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	324	324	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,132			$ 11,273	$ * (2,859)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 2,161	$ 2,161	15
16	V	32	Interest		Vent Lease, LLC.	100.00%	241	241	16
17	V	39	Vent Reimbursement	4,470	Vent Lease, LLC.	100.00%		(4,470)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,470			$ 2,402	$ * (2,068)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Noah Wolff	Owner	Administrative	16.67%	See Attached	10.00	28.57%	Mgmt Fee	$ 71,714	17-03	1
2	Eric Rothner	Owner	Administrative	33.33%	See Attached	0.88	1.91%	Mgmt Fee	3,870	17-03	2
3	Mark Steinberg	Relative	Administrative	0.00%	See Attached	3.00	5.45%	CCI Alloc.	1,711	17-07	3
4	Adam Vales	Relative	Clerical	0.00%	See Attached	0.60	1.50%	Alloc Clerical	621	22-03	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 77,916		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 92,031	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 92,031	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						24,197	3
4	04	LAUNDRY	Direct Allocation						217	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						78	5
6	10	NURSING	Direct Allocation						30,531	6
7	10A	THERAPY	Direct Allocation						3,970	7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						2,991	10
11	39	ANCILLARY	Direct Allocation						24,609	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 86,592	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	42,015	$ 275	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		42,015	1,050	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		42,015	1,121	3
4	10	Nursing	Patient Days	1,484,397	42			42,015		4
5	11	Activities	Patient Days	1,484,397	42			42,015		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		42,015	5,654	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		42,015	1,956	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		42,015	10,242	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		42,015	2,787	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		42,015	568	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		42,015	10,412	11
12	32	Interest	Patient Days	1,484,397	42			42,015		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		42,015	1,297	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		42,015	3,274	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		42,015	1,259	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 39,895	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		15,725	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			2,301	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		5,731	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		1,416	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		2,559	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			1,420	7
8	17	Administration Salary	Direct Cost			38,431	38,431		3,117	8
9	21	Office Salary	Direct Cost			525,935	525,935		16,798	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			2,913	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 51,980	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	42,015	2,507	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			42,015		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	42,015	3,740	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		42,015	914	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	42,015	13,072	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			42,015		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	42,015	7,553	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		42,015	3,017	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	42,015	9,538	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	42,015	92,778	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		42,015	14,845	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 147,964	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		14,132	614	1
2	02	Food	Billable Income	2,144,835		987,169		14,132	3,190	2
3	06	Maintenance	Billable Income	2,144,835		3,597		14,132	24	3
4	17	Administration	Billable Income	2,144,835		24,000		14,132	158	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		14,132	16	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		14,132	9	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		14,132	286	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		14,132	71	8
9	26	Insurance	Billable Income	2,144,835		9,262		14,132	61	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		14,132	9	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		14,132	329	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		14,132	7	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		14,132	3,963	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	14,132	2,212	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		14,132	324	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 11,273	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	4,470	$ 2,161	1
2	32	Interest	Direct Billing	620,670	29	33,493		4,470	241	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 2,402	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 4,062,905			$ 264,821	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Daiwa Loan		X	Working Capital				65,761			3,209	6
7												7
8	See Supplemental Schedule										250	8
9	TOTAL Facility Related						$	$ 4,128,666			$ 268,280	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,198)	10
11	Interest Income - Bldg Co		X								(639)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (20,837)	14
15	TOTALS (line 9+line14)						$	$ 4,128,666			$ 247,443	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 20,432 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Allocate Vent Lease LLC		X				$	$			$ 241	8
9	Allocate Care Centers		X								9	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										250	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	147,713	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	150,283	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,570	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	153,456	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	156,026	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	133,766	8
	2000	141,972	9
	2001	145,632	10
	2002	143,411	11
	2003	148,986	12

2003 Real Estate Tax Accrual = $148,986 X 1.05 = $153,456

Alloc. From Care Centers, Inc. = $1,297

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	24-05-302-003-0000	Long Term Care Property	$ 148,986.34	$ 148,986.34
2.	Home Office	See Attached	$ 106,873.39	$ 1,297.42
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 255,859.73	$ 150,283.76

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Concord Extended Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0026914

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,133 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	56,110	1962	$ 27,417	1
2	2201 Main, LLC Allocation			9,955	2
3	TOTALS	56,110		$ 37,372	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1974	1,435		20	-		1,435	9
10	Various			1976	4,663		20	-		4,663	10
11	Various			1977	2,336		20	-		2,336	11
12	Various			1978	765		20	-		765	12
13	Various			1980	33,145		20	-		33,145	13
14	Various			1982	2,378		20	-		2,292	14
15	Various			1983	45,375		20	1,815	1,815	38,156	15
16	Various			1985	21,344		20	853	853	16,567	16
17	Various			1986	31,133		20	1,557	1,557	28,767	17
18	Various			1988	41,219		20	1,662	1,662	27,770	18
19	Various			1989	3,324		20	166	166	2,544	19
20	Various			1990	8,400		20	420	420	5,915	20
21	Various			1991	34,006		20	1,702	1,702	23,464	21
22	Various			1992	8,695		20	435	435	5,373	22
23	Various			1993	11,679		20	585	585	6,833	23
24	Various			1994	29,410		20	1,472	1,472	15,527	24
25	Various			1995	118,494		20	5,927	5,927	55,180	25
26	Various			1996	68,945		20	3,449	3,449	28,386	26
27	Various			1997	54,013		20	2,701	2,701	20,121	27
28	Various			1998	158,651		20	7,933	7,933	51,446	28
29	Various			1999	40,891		20	2,045	2,045	12,006	29
30	Various			2000	123,534		20	6,179	6,179	27,132	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		1,945,046	50,347		57,012	6,665	1,179,839	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		38,404	1,578		1,578		3,276	68
69	Financial Statement Depreciation			68,444			(68,444)		69
70	TOTAL (lines 4 thru 69)		$ 2,827,285	$ 120,369		$ 97,491	$ (22,878)	$ 1,592,938	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,827,285	$ 120,369		$ 97,491	$ (22,878)	$ 1,592,938	1
2	Adt Security Service	2001	4,051		20	203	203	760	2
3	Voice Mail System	2001	997		20	50	50	183	3
4	Frig Ac	2001	660		20	33	33	121	4
5	Landscape	2001	959		20	48	48	172	5
6	Frig A/C	2001	(565)		20	(28)	(28)	(647)	6
7	Elevator Repairs	2001	717		20	36	36	123	7
8	Plumbing	2001	500		20	25	25	85	8
9	Fire Panel	2001	5,600		20	280	280	957	9
10	Plumbing	2001	500		20	25	25	81	10
11	Plumbing	2001	500		20	25	25	79	11
12	Plumbing	2001	1,916		20	49	49	194	12
13	Air Conditioner	2001	585		20	15	15	59	13
14	Plumbing	2001	632		20	16	16	64	14
15	Plumbing	2002	500		20	50	50	150	15
16	Plumbing	2002	500		20	50	50	150	16
17	Elevator Repair	2002	875		20	88	88	255	17
18	Blinds	2002	940		20	94	94	274	18
19	Tybony	2002	2,141		20	214	214	607	19
20	Painting	2002	1,437		20	144	144	407	20
21	Sewer Clean Outside	2002	1,500		20	150	150	425	21
22	Fire Service	2002	1,737		20	248	248	703	22
23	Fire Service	2002	1,000		20	143	143	405	23
24	Plumbing	2002	500		20	50	50	138	24
25	Plumbing	2002	500		20	50	50	129	25
26	Smoke Alarm	2002	502		20	72	72	185	26
27	Window Treatments	2002	2,448		20	245	245	612	27
28	Paint	2002	743		20	149	149	372	28
29	Walk In Cooler	2002	1,094		20	156	156	365	29
30	Telephone Equipment	2002	501		20	50	50	113	30
31	Heat Exchanger	2002	680		20	136	136	295	31
32	Huac	2003	2,838		20	142	142	189	32
33	Fix Bathroom Plumbing	2003	2,515		20	126	126	147	33
34	TOTAL (lines 1 thru 33)		$ 2,867,288	$ 120,369		$ 100,625	$ (19,744)	$ 1,601,090	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,867,288	$ 120,369		$ 100,625	$ (19,744)	$ 1,601,090	1
2	Locks	2003	3,798		20	380	380	728	2
3	Repair Hot Water Heater	2003	813		20	81	81	142	3
4	Door Key Pads	2003	875		20	88	88	153	4
5	Front Door	2003	4,800		20	480	480	720	5
6	Plumbing	2003	2,515		20	252	252	356	6
7	Steel Door	2003	950		20	95	95	135	7
8	Glass Door	2003	2,200		20	220	220	293	8
9	Exhaust System	2003	2,600		20	260	260	325	9
10	Code Alert - Alarm	2003	608		20	61	61	96	10
11	Oxygen Room	2004	1,100		20	110	110	110	11
12	Install Panic Device	2004	2,521		20	252	252	252	12
13	Advance Build Wall In Dty Dept	2004	1,250		20	125	125	125	13
14	Plumbing	2004	2,894		20	145	145	145	14
15	Plumbing	2004	769		20	38	38	38	15
16	Plumbing	2004	1,496		20	75	75	75	16
17	Plumbing	2004	1,260		20	63	63	63	17
18	Patch Utility Cut	2004	700		20	35	35	35	18
19	Install Air Conditioner	2004	5,771		20	289	289	289	19
20	Hvac*	2004	2,305		20	115	115	115	20
21	Paint Plaster & Drywall	2004	5,000		20	250	250	250	21
22	Repair Duct Work	2004	1,261		20	126	126	126	22
23	Basement Work	2004	1,580		20	66	66	66	23
24	Office Equipment	2004	572		20	24	24	24	24
25	Nurse Call System	2004	575		20	34	34	34	25
26	Electrical Work	2004	3,761		20	313	313	313	26
27	Drain Tile Installation	2004	2,200		20	61	61	61	27
28	Electrical	2004	693		20	46	46	46	28
29	Electrical Repair	2004	695		20	46	46	46	29
30	Install Sprinkler Heads	2004	1,500		20	50	50	50	30
31	Sprinkler Installation	2004	1,195		20	60	60	60	31
32	Install Heat Exchanger	2004	1,490		20	75	75	75	32
33	Motor	2004	978		20	49	49	49	33
34	TOTAL (lines 1 thru 33)		$ 2,928,013	$ 120,369		$ 104,989	$ (15,380)	$ 1,606,485	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,928,013	$ 120,369		$ 104,989	$ (15,380)	$ 1,606,485	1
2	Pressure Test	2004	3,953		20	99	99	99	2
3	Generator Maintenance	2004	1,290		20	32	32	32	3
4	Valve In Boiler Room	2004	659		20	22	22	22	4
5	Motor	2004	1,564		20	313	313	313	5
6	Antenna	2004	650		20	119	119	119	6
7	New Rehab Room	2004	1,763		20	323	323	323	7
8	Kitchen Fire Suppression System*	2004	1,463		20	174	174	174	8
9	Replace Door Holder	2004	1,657		20	276	276	276	9
10	Delay Lock For Basement*	2004	1,446		20	241	241	241	10
11	Motor Replacement	2004	5,879		20	980	980	980	11
12	Motor Replacement	2004	987		20	165	165	165	12
13	Electrical Work*	2004	582		20	97	97	97	13
14	Fire Rated Device*	2004	961		20	114	114	114	14
15	100 Watt Amplifier*	2004	817		20	123	123	123	15
16	Motor	2004	504		20	67	67	67	16
17	A/C Startup	2004	1,301		20	173	173	173	17
18	Bldg Improvements	2004	764		20	76	76	76	18
19	Keypad For Elevator	2004	955		20	88	88	88	19
20	Elevator Door Detector Edge*	2004	2,850		20	238	238	238	20
21	Repair Walls	2004	4,475		20	298	298	298	21
22	Carpeting*	2004	2,578		20	215	215	215	22
23	Install New Circuits	2004	1,016		20	8	8	8	23
24	Wire Emergency Generator	2004	4,624		20	39	39	39	24
25	Plumbing Repairs	2004	2,100		20	210	210	210	25
26	Repair Valve In Boiler Room	2004	2,219		20	222	222	222	26
27	Repair Water Lines	2004	1,253		20	125	125	125	27
28	Landscaping*	2004	471		20	24	24	24	28
29	Locks And Key Pads*	2004	1,804		20	90	90	90	29
30	Keypad For Elevator*	2004	573		20	29	29	29	30
31	Painting*	2004	19,700		20	985	985	985	31
32	Hvac*	2004	18,705		20	935	935	935	32
33	Parking Lot*	2004	4,750		20	238	238	238	33
34	TOTAL (lines 1 thru 33)		$ 3,022,326	$ 120,369		$ 112,126	$ (8,243)	$ 1,613,623	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,022,326	$ 120,369		$ 112,126	$ (8,243)	$ 1,613,623	1
2	Concrete West Side Entrance*	2004	4,750		20	238	238	238	2
3	Concrete West Side Entrance	2004	275		20	14	14	14	3
4	Northside Ramp*	2004	2,300		20	115	115	115	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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18									18
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,029,651	$ 120,369		$ 112,493	$ (7,876)	$ 1,613,989	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1962	1962	$ 339,532	$		$	$	$	4
5			1987	1987	1,493,264	50,347		57,012	6,665	1,179,839	5
6			1962	1962	112,250						6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,945,046	$ 50,347		$ 57,012	$ 6,665	$ 1,179,839	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC Allocation		2002		$ 13,718	$ 343		$ 343	$	$ 857	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main, LLC Allocation			2002	11,332	567	20	567		1,417	9
10	2201 Main, LLC Allocation			2003	13,354	668	20	668		1,002	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 38,404	$ 1,578		$ 1,578	$	$ 3,276	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 414,805	$ 5,456	$ 37,761	$ 32,305	10	$ 264,348	71
72	Current Year Purchases	109,964	4,089	32,581	28,492	10	32,581	72
73	Fully Depreciated Assets	390,195				10	390,195	73
74								74
75	TOTALS	$ 914,964	$ 9,545	$ 70,342	$ 60,797		$ 687,124	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated - Care Center		2004	$ 19,333	$ 1,406	$ 1,406	$	5	$ 16,281	76
77	Allocated - Care Center		2004	295	44	44		5	44	77
78										78
79										79
80	TOTALS			$ 19,628	$ 1,450	$ 1,450	$		$ 16,325	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,001,615	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,364	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 184,285	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 52,921	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,317,438	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocate Care Centers				3,603			5
6								6
7	TOTAL				$ 3,603 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,540 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care | STATE OF ILLINOIS # 0026914 | Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 128,896	$		$ 128,896	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			6,547			6,547	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			130,701			130,701	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				112,292		112,292	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					615	126,379		126,994	13
14	TOTAL			$		$ 266,759	$ 238,671		$ 505,430	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,868	$ 13,642	1
2	Cash-Patient Deposits	46,619	46,619	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	816,875	816,875	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	134,612	175,602	6
7	Other Prepaid Expenses	1,554	1,554	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	18,800	297,179	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,020,328	$ 1,351,471	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		27,417	13
14	Buildings, at Historical Cost		2,069,821	14
15	Leasehold Improvements, at Historical Cost	927,544	927,544	15
16	Equipment, at Historical Cost	972,145	972,145	16
17	Accumulated Depreciation (book methods)	(1,119,751)	(2,299,065)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		72,974	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 779,938	$ 1,770,836	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,800,266	$ 3,122,307	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,115,085	$ 1,123,484	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,837	36,837	28
29	Short-Term Notes Payable	65,761	65,761	29
30	Accrued Salaries Payable	79,585	79,585	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,164	4,164	31
32	Accrued Real Estate Taxes(Sch.IX-B)		153,456	32
33	Accrued Interest Payable		21,940	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	13,077	13,077	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,314,509	$ 1,498,304	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,062,905	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,062,905	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,314,509	$ 5,561,209	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 485,757	$ (2,438,902)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,800,266	$ 3,122,307	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 813,642	1
2	Restatements (describe):		2
3	**Depreciation Adjustment**	(14,319)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 799,323	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(313,566)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (313,566)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 485,757	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,170,431	1
2	Discounts and Allowances for all Levels	(1,208,623)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,961,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,124,751	6
7	Oxygen	44,355	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,169,106	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5	14
15	Telephone, Television and Radio	284	15
16	Rental of Facility Space		16
17	Sale of Drugs	114,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	27,865	19
20	Radiology and X-Ray	2,475	20
21	Other Medical Services	142,815	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 287,544	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,198	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,198	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,322	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,322	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,439,978	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	972,589	31
32	Health Care	2,152,331	32
33	General Administration	1,460,498	33
	B. Capital Expense		
34	Ownership	589,130	34
	C. Ancillary Expense		
35	Special Cost Centers	505,430	35
36	Provider Participation Fee	73,566	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,753,544	40
41	**Income before Income Taxes (line 30 minus line 40)****	(313,566)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (313,566)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,935	2,178	$ 67,306	$ 30.90	1
2	Assistant Director of Nursing	1,490	1,707	46,795	27.41	2
3	Registered Nurses	7,541	8,607	204,175	23.72	3
4	Licensed Practical Nurses	21,997	24,161	553,776	22.92	4
5	Nurse Aides & Orderlies	72,999	79,158	770,989	9.74	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,788	5,372	73,822	13.74	8
9	Activity Director	1,699	1,991	20,228	10.16	9
10	Activity Assistants	6,260	6,906	56,228	8.14	10
11	Social Service Workers	5,793	6,557	94,085	14.35	11
12	Dietician					12
13	Food Service Supervisor	1,983	2,329	37,693	16.18	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,461	18,829	162,659	8.64	15
16	Dishwashers					16
17	Maintenance Workers	2,835	3,381	42,938	12.70	17
18	Housekeepers	17,524	19,254	168,620	8.76	18
19	Laundry	8,167	9,050	82,458	9.11	19
20	Administrator	1,939	2,119	78,397	37.00	20
21	Assistant Administrator	1,586	1,685	36,436	21.62	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,066	4,449	80,497	18.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,109	2,262	34,358	15.19	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	182,172	199,995	$ 2,611,460 *	$ 13.06	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	185	$ 8,210	01-03	35
36	Medical Director	Monthly	5,960	09-03	36
37	Medical Records Consultant	Monthly	4,355	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,356	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,238	11-03	44
45	Social Service Consultant	116	6,291	12-03	45
46	Other(specify) Psych. (PY - Adj P. 5)		300	10-03	46
47					47
48	CCI Allocation (See Attached)		14,560	Various	48
49	TOTAL (lines 35 - 48)	349	$ 43,270		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	822	$ 41,947	10-03	50
51	Licensed Practical Nurses	3,022	101,998	10-03	51
52	Nurse Aides	23	437	10-03	52
53	TOTAL (lines 50 - 52)	3,867	$ 144,382		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Lee	Administrator	0	$ 78,397
Basya Schwarcz	Asst Admin	0	36,436
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,833

B. Administrative - Other

Description	Amount
CCI - Administrative Payroll	$ 3,117
Management Fee - Eric Rothner	3,870
Management Fee - Noah Wolff	71,714
TOTAL (agree to Schedule V, line 17, col. 3)	$ 78,701
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Data Processing	$ 8,709
Care Centers, Inc.	Data Processing	4,788
Maxxsource Computer	Data Processing	100
Care Centers, Inc.	Home Office Expense	113,050
Care Centers, Inc.	Ancillary Admin. Expense	14,630
Care Centers, Inc.	Bookkeeping	27,132
Care Centers, Inc.	Accounting	15,000
FR&R	Accounting	29,950
See Attached Schedule	Legal	6,052
Care Centers, Inc.	Legal	12,136
Personnel Planners	Unemployment Consultant	2,340
See Supplemetal Schedule		9,566
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 243,453

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 77,748
Unemployment Compensation Insurance	26,308
FICA Taxes	193,180
Employee Health Insurance	57,132
Employee Meals	21,338
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	4,920
Employee Welfare	7,324
Union Dues	1,061
TOTAL (agree to Schedule V, line 22, col.8)	$ 389,011

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,750
Advertising: Employee Recruitment	15,628
Health Care Worker Background Check	1,938
(Indicate # of checks performed)	
Dues and Subscriptions	3,999
Licenses and Fees	2,337
Allocate Care Centers	1,965
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,617

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,467
Allocate Care Centers	2,858
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,325

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Concord Extended Care # 0026914 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IL Council on Long Term Care $4,812

(3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 3,040 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 73,566
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 21,338 Has any meal income been offset against related costs? Yes Indicate the amount. $ 5

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? None
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.